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No. _____

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

CESAR A. PERALES, as Commissioner of Social Services of the State of New York,

Petitioner,

—v—

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; MEDICAL SOCIETY OF THE STATE OF NEW YORK; SIDNEY FINKEL, JOHN A. BLESKI, and LOUIS W. SULLIVAN, as Secretary of the United States Department of Health and Human Services,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

May a State limit Medicaid reimbursement to the Medicaid rate of payment for services rendered to Medicaid recipients enrolled by the State in the Medicare program?

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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; MEDICAL SOCIETY OF THE STATE OF NEW YORK; SIDNEY FINKEL, JOHN A. BLESKI, and LOUIS W. SULLIVAN, as Secretary of the United States Department of Health and Human Services,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The Commissioner of Social Services of the State of New York petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

OPINIONS BELOW

The opinion of the Court of Appeals (Appendix, *infra*, 1a-34a) is reported at 954 F.2d 854 (2d Cir. 1992). The opinion of the District Court (Appendix, *infra*, 35a-48a) is unreported.

JURISDICTION

The judgment of the Court of Appeals was entered on February 3, 1992. Rehearing was denied on May 20, 1992. (Appendix, *infra*, 49a). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATION INVOLVED

The New York State Medicaid regulation challenged in this case, 18 New York Code, Rules and Regulations ("N.Y.C.R.R.") § 360-7.7 (1989) (formerly codified at 18 N.Y.C.R.R. § 360.10) and the relevant provisions of the federal Medicare and Medicaid Acts, specifically, 42 U.S.C. §§ 1395cc(a)(2)(A), 1396a(a)(10)(E)(i), 1396a(n) and former § 1396a(a)(15), respectively, are reproduced in the Appendix (*infra*, 50a-55a).

STATEMENT

This case involves a challenge under the Medicare and Medicaid statutes, Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc and §§ 1396 *et seq.*, respectively, to a New York State Medicaid regulation (18 NYCRR § 360-7.7) that was approved by the Secretary of the United States Health and Human Services (the "Secretary"). The challenged regulation limits Medicaid reimbursement to the Medicaid-approved rate for those providing medical services to persons who are eligible under both Medicaid and Medicare. These individuals are sometimes referred to as "dual-eligible" or "cross-over" beneficiaries.

Medicaid is a joint federal and state program providing medical care to poor persons. 42 U.S.C. § 1396 *et seq.* Individual states administer the Medicaid program pursuant to a state plan approved by the Secretary. 42 U.S.C. § 1396a. The state plan must include, among other things, a schedule of payment for the medical services covered by the program. 42 U.S.C. § 1396a(a)(13). The federal government reimburses

the states for a portion of their Medicaid expenditures, which for New York is 50 percent. 42 U.S.C. § 1396*b*. The Medicaid program reimburses those providing services to Medicaid recipients at the Medicaid-approved rate of payment, but only after any "third party" insurance coverage has been exhausted. 42 U.S.C. § 1396a(a)(25). Providers participating in the Medicaid program must accept as payment in full the Medicaid rate of payment, and may not charge in excess of that amount. 42 U.S.C. § 1396h(d); 42 C.F.R. § 447.15.

Medicare is exclusively a federally funded and administered program providing health insurance to the elderly and certain disabled persons. 42 U.S.C. §§ 1395 *et seq*. The Medicare program is composed of two parts: Part A provides insurance for hospital care, and Part B provides supplemental insurance for physician and other health services. 42 U.S.C. §§ 1395c–1395*i*-4 and 1395j–1395w-4. Part A coverage is provided by the federal government to all Medicare-eligible persons, while Part B is voluntary coverage which may be purchased.

Those eligible for Medicare Part B can enroll in the program by paying monthly premiums. 42 U.S.C. § 1395r. The Medicare program pays 80% of the approved charge or reasonable charge established by the Secretary for a given service (after the beneficiary has paid the annual deductible), and the beneficiary is responsible for paying the remaining 20% as a co-payment. Section 1395*l*(a)(1). Physicians in the Medicare program must accept as payment in full the Medicare approved charge or reasonable charge for a given service. 42 U.S.C. § 1395u(b)(3)–(B)(ii). The physician submits a claim to Medicare and is reimbursed for 80% of the charge. The physician then may charge the Medicare-only beneficiary for the co-payment. 42 U.S.C. § 1395cc(a)(2)(A).

Under the Medicare Act, states can enroll their dual-eligible beneficiaries in Medicare by paying the Medicare premiums on their behalf. 42 U.S.C. § 1395v; 42 CFR § 407.40–407.50. In essence, these "buy in" agreements allow the states to purchase Medicare coverage as "third party"

insurance for their Medicare-eligible Medicaid recipients. Such recipients would not otherwise be covered by Medicare Part B.

In 1986, Congress amended the Medicaid statute to authorize states also to enroll in Medicare a category of beneficiaries referred to as "qualified Medicare beneficiaries" ("QMBS"). 42 U.S.C. § 1396a(a)(10)(E)(i). QMBs now include Medicaid-eligible as well as the "near poor", *i.e.*, those whose income is equal to or less than 100% of the federal poverty level, whose resources do not exceed twice the eligibility level for Supplemental Security Income ("SSI") under 42 U.S.C. § 1382a, and who are entitled to Medicare Part A coverage. 42 U.S.C. § 1396d(p)(3). With respect to the amounts to be paid by the states for QMBs enrolled in Medicare, the Medicaid Act permits, but does not require, the states to pay Medicare "cost-sharing" amounts for QMBs (deductibles and co-payments) that result in payments in excess of Medicaid rates. 42 U.S.C. § 1396a(n).

Under the Secretary's interpretation of the Medicaid Act, a state "is not necessarily obligated to pay the full amount of the deductibles and coinsurance costs according to the rates established under Title XVIII [Medicare], but only that amount which will satisfy the requirement for payment in full according to the Title XIX [Medicaid] method of payment." *See* Memorandum dated January 10, 1986, from Richard P. Kisserow, Inspector General, Department of Health and Human Services, to C. McClain Haddow, Health Care Financing Administration. Prior to 1987, however, New York State's Medicaid program provided for reimbursement of all cost sharing amounts. To contain Medicaid costs, the Secretary encouraged states like New York to limit Medicaid reimbursement for cost-sharing amounts to the Medicaid rate. Accordingly, New York, in 1987, submitted a Medicaid plan amendment to incorporate the challenged regulation in its

State plan. On March 16, 1988, the Secretary approved the amendment.[1]

Under the New York regulation, effective in 1987, the Medicaid program in New York State would reimburse providers for the 20% Medicare co-payment up to the Medicaid rate, provided the amount paid by Medicare did not equal or exceed the Medicaid rate. 18 NYCRR § 360-7.7(a)-(b). New York would continue to pay the premiums of dual-eligible beneficiaries and providers would continue to receive a higher level of reimbursement than the Medicaid rate to the extent that the Medicare 80% payment exceeded the Medicaid rate.

Thus, under the New York regulation, Medicaid would provide the same amount of reimbursement to medical providers regardless of whether the patients they have treated are Medicaid-eligible only or are dual-eligible beneficiaries. As with Medicaid only recipients, providers are prohibited from looking to dual-eligible beneficiaries for any payment. Since the Medicare payment is often higher than the Medicaid-approved rate, however, these providers often would receive higher reimbursement when the patient is a dual-eligible beneficiary.

On July 8, 1987, respondents (other than the Secretary) commenced this action, pursuant to 42 U.S.C. § 1983, in the U.S. District Court for the Southern District of New York against petitioner and respondent Secretary. Respondents sought declaratory and injunctive relief on the ground that the challenged regulation violates the Medicare and Medicaid Acts because it does not allow providers to recover, in addition to the Medicare payment, the full amount of the 20% co-payment for dual-eligible beneficiaries, without limitation to the Medicaid-approved rate.

The parties cross moved for summary judgment. In an opinion and order dated March 18, 1991, the district court

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1 Upon information and belief, approximately 30 other states have adopted limitations on Medicaid reimbursement similar to the challenged regulation.

(Lowe, D.J.) granted petitioner's and the Secretary's motions. The court found that the Secretary's approval of the challenged regulation was based upon a rational interpretation of complex and ambiguous statutes.

In effect at the time that the case was briefed in the District Court was the predecessor to 42 U.S.C. § 1396a(a)(10)(E), former section 1396a(a)(15). (Appendix, *infra*, 55a) The Secretary interpreted this provision as regulating the payment of cost-sharing amounts only when, under a state's plan, the provider is allowed to collect some portion of the cost-sharing amount from the dual-eligible beneficiary. In that circumstance, the state plan must take into account the beneficiary's "income or his income and resources." Respondents, on the other hand, interpreted this provision as requiring the state plan to provide for payment in full of all cost-sharing amounts, less any portion imposed upon the beneficiary determined in accordance with the beneficiary's means.

The District Court held that under *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842-43 (1984),[2] the Secretary's interpretation was entitled to deference and should be upheld. On April 29, 1991, the District Court entered a final judgment in favor of petitioner and the Secretary.

On appeal, a divided Court of Appeals for the Second Circuit reversed the judgment below and annulled the challenged regulation. (Appendix, *infra*, 1a-34a) The majority opinion found that the Secretary's approval of the challenged regulation was inconsistent with the Medicare Act and the "buy in" provisions in the Medicaid Act. (*Id.*, 1a-20a) The major-

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2 *Chevron* holds that when "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." 467 U.S. at 843. The agency's interpretation is permissible and must be upheld so long as it is not "manifestly contrary" to the statute. *Id.*, at 845.

ity specifically interpreted 42 U.S.C. § 1395cc(a)(2)(A),[3] as granting the provider a right to collect the 20% co-payment whenever payment is made under Medicare Part B, even when the patient is a dual-eligible beneficiary. (*Id.*, 9a) The Court of Appeals thus held that the New York State Medicaid program is required to pay the full 20% co-payment of dual-eligible beneficiaries, without limitation to the Medicaid rate. (*Id.*, 10a-11a)

In dissent, Judge Cardamone noted that neither the Medicare and Medicaid Acts nor the relevant legislative history express an intent on the part of Congress to require states under "buy in" agreements to reimburse providers without limitation up to the Medicare charge level. Like the district court, Judge Cardamone concluded that under *Chevron* and other precedents of this Court, the Secretary's interpretation of the statutes was reasonable, and was entitled to deference.[4] (Appendix, *infra*, 31a-34a).

REASONS FOR GRANTING THE PETITION

In 1988, the Secretary approved New York's regulation to limit Medicaid reimbursement for dual-eligible beneficiaries to the Medicaid rate. At the present time, upon information and belief, the Secretary has approved approximately 30 other similar state regulations. Although the Second Circuit's decision is the only decision by an appellate court to construe the validity of the Secretary's policy on dual-eligibles, the decision should be reviewed now for four reasons: first, the

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3 This section provides that the physician in the Medicare program "may charge" the 20% co-payment, but does not specifically provide that the physician has the right to collect the 20% co-payment when he has treated a Medicaid-eligible patient enrolled in Medicare by the State under a "buy in" agreement.

4 It is estimated that this requirement will cost the Medicaid program in New York State more than $50 million annually. Moreover, the provider respondents have communicated their intention to commence litigation in state court and will try to use the Court of Appeals' opinion collaterally against the State to obtain millions of dollars in retroactive relief through 1987, when the challenged regulation was adopted.

decision has national significance because of the existence of similar regulations in a majority of the states (*see Simon & Schuster v. Members of the New York State Crime Victims Board*, ____ U.S. ____, 112 S.Ct. 501, 508 [1991]); second, the decision involves a significant and unresolved issue of statutory and regulatory interpretation involving the interplay between the Medicaid and Medicare Acts as applied to dual-eligible beneficiaries; third, the majority and dissenting opinions of the Second Circuit contain a comprehensive analysis of the distinct legal positions that would be presented in this Court by the parties; and fourth, the Second Circuit's decision has immediate and drastic fiscal consequences for New York which already is facing severe budgetary constraints.

Review of the Court of Appeals' decision will provide this Court with the opportunity to further define the *Chevron* standard. The majority opinion relied principally upon its interpretation of section 1395cc(a)(2)(A) of the *Medicare* Act and legislative history applicable primarily to Medicare Part A in refusing to adopt the Secretary's interpretation, and in reaching the conclusion that the provider has a right to collect 100% of the Medicare charge level even when treating a dual-eligible beneficiary.

The dissent and the District Court, on the other hand, noted the absence of express language in this section or elsewhere in the Act supporting such a conclusion. Faced with an ambiguous and, as the majority opinion acknowledged, "a complicated statutory scheme,"[5] they followed the reasoning in *Chevron* and deferred to the Secretary's interpretation.

The Secretary's interpretation is supported by language in the *Medicaid* Act, which provides that states enrolling QMBs in Medicare "may", but are not required, to pay Medicare co-payments and deductibles, in excess of the Medicaid rate.

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5 This Court has similarly observed that the "Social Security Act is among the most intricate drafted by Congress. Its Byzantine construction, as Judge Friendly observed, makes the Act 'almost unintelligible to the uninitiated.' " *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting from *Friedman* v. *Berger*, 547 F.2d 724, 727 n.7 [2d Cir. 1976], *cert. denied*, 430 U.S. 984 [1977]).

42 U.S.C. § 1396a(n). *See Farmers Merchants Bank of Monroe, N.C.* v. *Federal Reserve Bank*, 262 U.S. 649, 662 (1923) ("may" ordinarily connotes discretion). In contrast to the section of the Medicare Act relied upon in the majority opinion (42 U.S.C. § 1395cc[a][2][A]), which deals generally with physicians' charges to Medicare beneficiaries, this section of the Medicaid Act deals specifically with payment for services to QMBs enrolled by the states in Medicare. *See Busic* v. *United States*, 446 U.S. 398, 406 (1980) ("a more specific statute will be given precedence over a more general one.").

In rejecting the Secretary's interpretation of the Medicaid and Medicare Acts, the majority opinion erroneously failed to apply the principle of deference to the Secretary's construction of complex Medicaid and Medicare statutes, *see e.g.*, *Chevron USA Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984); *Morton v. Ruiz*, 415 U.S. 199, 231 (1974). The majority refused to defer to the Secretary's interpretation, based on its reasoning that the general provision in the Medicare Act, that providers may collect their reasonable costs or charges, contains no exception for dual-eligible beneficiaries, and that therefore New York's regulation "appears, on its face, to violate the Medicare Act." (Appendix, *infra*, 10a). However, as the dissenting opinion points out, the delegation of agency authority may be implicit rather than explicit and nothing in the relevant statutes fairly supports the conclusion that Congress specifically intended providers of dual-eligible beneficiaries to be reimbursed at the full Medicare reasonable cost/charge standard. (Appendix, *infra*, 22a)

The Secretary's position, that dual-eligible beneficiaries are "primarily Medicaid patients" and that state plans need only provide reimbursement for these patients in conformance with the standards in the Medicaid Act, is not only reasonable but is supported by the legislative history, as the dissenting opinion points out. The relevant legislative history demonstrates that Congress desired to ensure full reasonable cost/charge reimbursement only under Medicare Part A, and that Congress did not necessarily assume the same standard

of reimbursement for dual-eligible beneficiaries under the voluntary elective Part B program. *See* S. Rep., No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1964-2011. (Appendix, *infra*, 26a-27a) (dissenting opinion below). The Senate Report distinguishes between Part A and Part B payment by the states, and with respect to Part B, states that "[a] State medical assistance plan *may* provide for the payment in full of any deductibles or cost sharing under [Part B]. *Id.* at 2019-2020 (emphasis added) (Appendix, *infra*, 30a) (dissenting opinion).

The majority's opinion also ignores provisions and objectives of the Medicaid Act which are more applicable to dual-eligible beneficiaries than are the ambiguous provisions of the Medicare Act. The objective of the Medicaid program is, "*as far as practicable*, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services." *Beal v. Doe*, 432 U.S. 438, 444 (1977) (emphasis added). Congress granted the states the authority to administer the Medicaid program under this broad directive, and the states' determinations on how to fund their programs need only accord with "reasonable standards . . . for determining . . . the extent of medical assistance under [its] plan . . . which are consistent with the objectives" of the Medicaid Act. *Id.*, at 441 (quoting from 42 U.S.C. § 1396a[a][17]). The Second Circuit's decision thus interferes with New York's broad statutory authority to determine rates of payment in conformance with the Medicaid Act.

Moreover, the majority opinion, in contrast to the dissent and the District Court, appears to treat all dual-eligible beneficiaries as if they are like all other Medicare patients, and their providers, like all other Medicare providers. It is undisputed that providers may not collect more than the Medicaid rate of payment when treating Medicaid-only recipients. 42 U.S.C. § 1396h(d). Medicaid recipients, when also eligible for Medicare, remain Medicaid recipients states and indeed are only enrolled in the Medicare program by the states by virtue of their status as Medicaid recipients. Part B Medicare cover-

age, when purchased by the states for dual-eligible beneficiaries, is no different from any other kind of "third party" insurance coverage which must be exhausted before Medicaid will pay the provider up to the Medicaid rate.

The majority opinion's holding—recognizing in providers a right to collect the full amount of the co-payment, in excess of the Medicaid rate, for services rendered to all dual-eligible beneficiaries—cannot be reconciled with the reality that the beneficiaries the providers are treating are primarily Medicaid patients. Furthermore, it grants providers an unjustified windfall of higher reimbursement for having treated dual-eligible beneficiaries, solely by virtue of the fact that the State has enrolled them in the Medicare program. The Court of Appeals' decision creates the anomaly of a two-tiered, unequal Medicaid reimbursement scheme, one for Medicaid-eligible only, and another higher level for Medicaid-eligible who also happen to be Medicare-eligible.

Finally, the Court of Appeals' opinion means that New York State must now pay providers the full 20% co-payment for services to all dual eligible beneficiaries, without limitation to the Medicaid rate. As noted earlier, this requirement will cost the State millions of dollars annually, and may result in retroactive payment in the millions of dollars, as well. The issue is of great importance to many other states, as some thirty other states throughout the country have adopted Medicaid regulations that similarly limit Medicaid reimbursement. Unless this issue is resolved by this Court now, these states face the prospect of judicial challenges in reliance upon the Second Circuit's opinion, putting into jeopardy their Medicaid programs and their multi-million-dollar budgets.[6] Resolution of this issue by this Court now will eliminate this uncertainty and, if favorable to petitioner, will reinstate and preserve an enormous cost savings to the Medicaid program in New York State and in many other states.

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6 Upon information and belief, two such challenges have already been brought in Pennsylvania and Alabama.

CONCLUSION

The petition for a writ of certiorari should be granted.

Dated: New York, New York
August 18, 1992

Respectfully submitted,

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